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ABSTRACT

Because of the importance of nutrition during teenage pregnancies, the Illinois State Council on Nutrition held public hearings in Chicago and in Carbondale, areas having a high incidence of infant mortality. Several issues were identified: (1) effects on nutrition of low income, poor nutrition habits, and lack of understanding of the increased needs during pregnancy and of the relations between good nutrition and fewer complications during pregnancy and a healthy infant; (2) adolescents' lack of knowledge of nutrition and how it affects the course of pregnancy and the unborn baby; (3) accessibility to the school lunch program and its inadequate supply of food for pregnant students; (4) lack of available programs or lack of knowledge of where to find programs; (5) updating of nutrition knowledge for those involved in the education of adolescents and those working with them during pregnancy; and (6) the need for a course on parenting, responsibility education, human sexuality, and self-image. Testimony of witnesses at the hearing is reported on each of these issues. Behavior patterns of teens identified in the testimony are outlined, and pertinent statistics regarding the extent and problems of teenage pregnancy in Illinois are noted. (JD)

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REPORT ON NUTRITION AND TEENAGE PREGNANCY HEARINGS

Representative Peter P. Peters, Chairman

SP024337

ILLINOIS STATE COUNCIL ON NUTRITION

REPORT ON NUTRITION AND TEENAGE PREGNANCY HEARINGS

Quotes From Testimony:

"When we sat and talked that morning, Tina (age sixteen) looked down at her huge belly and she just said to me, 'I was the last of all my friends to get pregnant. They all had their babies a year ago. Nowadays, I guess having a baby is just part of growing up.'"

"Imagine if you will, a high school girl, pregnant, between the ages of 14-19. She may be an entering Freshman or a graduating Senior. She may be the youngest child still living at home, or she may be the oldest of several children. She may have a single parent--mother or father--or she may live with both parents. She may be an honor student or she may be classified as Educable Mentally Handicapped. Her parents may be blue-collar workers, owning their home, or she may be living in utter poverty in a housing project on a fixed income. She may marry before the baby is born--but often, she does not. She may have a supportive boyfriend or husband, but often she does not. She may have supportive family members or she may not. She may be college bound, or she may continue on the welfare cycle preset by generations before her. The profile of the pregnant teen is one who is distressful, lonely, unhappy in the pregnant state, and lacking self-esteem."

January, 1982

Report Written for the Council by:

Dorice M. Narins, Ph.D., Chairman
Maternal and Child Nutrition Task Force

Virginia R. Hill
Executive Director

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INDIVIDUALS WHO TESTIFIED AT HEARINGS

The following individuals testified at the hearing held on September 15, 1981, in Chicago:

John Barton, M.D., Chief of Department of Obstetrics and Gynecology, Illinois Masonic Medical Center, and Chairman, Illinois Section, American College of Obstetrics and Gynecology, Chicago, Illinois.

Eileen Ogintz, Reporter, CHICAGO TRIBUNE, Chicago, Illinois.

Betty Taif, Director of Nutrition, Chicago Department of Health, Chicago, Illinois.

Frances Ginther, R.N., Coordinator of Perinatal Education, Chicago Department of Health, Chicago, Illinois.

Joyce Garrick, Public Health Nutritionist, Chicago Department of Health, Chicago, Illinois.

Barbara Michelin, R.N., Executive Director of Crossroads Clinic, Rolling Meadows, Illinois. Also representing the National Foundation of the March of Dimes.

Donald M. Sherline, M.D., Director of Maternal-Fetal Medicine at Rush, Presbyterian, St. Luke's Medical Center, Chicago, Illinois.

Peggy Nickola, R.D., Nutritionist, Rush, Presbyterian, St. Luke's Medical Center, Chicago, Illinois.

Laurie Kuljis, Coordinator of Nutrition Consultation Service at Rush, Presbyterian, St. Luke's Medical Center, Chicago, Illinois.

Margie N. Johnson, R.D., Coordinator of Nutrition at Mile Square Health Center, Chicago, Illinois.

Beth O'Laughlin, Coordinator of Nutrition Education and Training Program at Center for Urban Education, Chicago, Illinois.

The following individuals testified at the hearing held on September 17, 1981, in Carbondale:

Barbara Connell, R.N., School Nurse at Meridian School District #101, Mounds, Illinois.

Allison Blake, pregnant student from Meridian High School, Mounds, Illinois.

Robin Lynn Barbsdale, pregnant student from Meridian High School, Mounds, Illinois.

Nancy Rowland, Nutritionist at Christopher Rural Health Initiative,
Christopher, Illinois.

Sandra Zabel Lutzker, Project 12-Ways Unwed Mother's Program,
Southern Illinois University, Carbondale, Illinois.

Debra Braunling-McMorrow, Counselor, Rehabilitation Institute,
Project 12-Ways Unwed Mother's Program, Southern Illinois
University, Carbondale, Illinois.

Kevin Hill, Health Educator, Southern Seven Health Department,
Ullin, Illinois.

Myra Wood Bennett, Social Worker, Southern Seven Health Department,
Ullin, Illinois.

Janet Maass, Acting Nutrition Services Coordinator, Illinois Depart-
ment of Public Health, Springfield, Illinois.

Fred Isberner, Director of Adolescent Health Center, Carbondale,
Illinois.

Roger Klam, M.D., Carbondale Clinic, Carbondale, Illinois.

M. Bunny Shupe, Coordinator, Rural Health Initiative Problem
Pregnancy Project, Anna, Illinois.

Cathy Kapros, Christopher Rural Health Initiative, Christopher,
Illinois. (Read testimony prepared by Connie Jones.)

Alma Hicks, Home Economics Teacher, Murphysboro High School,
Murphysboro, Illinois.

James Setchfield, M.D., Physician, Rural Health Initiative, Anna,
Illinois.

April Vyborny, R.N., Southern Seven Health Department, Ullin,
Illinois.

The following individuals testified at the hearing held on
September 29, 1981, in Chicago:

Audria M. Huntington, Program Administrator of the Northside
Service Center, and Assistant to Representative Jesse White,
Chicago, Illinois.

Shirley Fleming, R.N., Certified Nurse-Midwife, Chicago Department
of Health, (Simpson Alternative School), Chicago, Illinois.

Suzanne Hinds, Chairperson, Illinois Caucus on Teenage Pregnancy,
Chicago, Illinois.

Vickie Pasley, Maternal Project Coordinator, Cook County Department of Public Health, Maywood, Illinois.

Mary Murray, Nutritionist, Cook County Department of Public Health, Maywood, Illinois.

Patricia Walker Williams, Teacher and Coordinator of Cooperative Parenting Education (COPE) Program, Bloom Trail High School, Chicago Heights, Illinois.

Tammy Weigand, pregnant student in COPE program at Bloom Trail High School, Chicago Heights, Illinois.

Fern Barushok, Program Coordinator, Salvation Army Booth Hospital, Chicago, Illinois.

Jean Herron, Principal of Simpson Alternative School, Chicago, Illinois.

Dr. William M. Jones, Director of Dropout Prevention Program, Chicago Board of Education, Chicago, Illinois.

Dr. Evelyn Green, Principal, Bousfield Alternative School, Chicago, Illinois.

Manisha H. Maskay, Clinical Nutritionist, Hyde Park Kenwood Community Health Center, Chicago, Illinois. Also a Consultant at the Arts of Living Institute.

The following individuals did not testify at the hearings but submitted written testimony:

Connie Jones, Supervising Nurse, Obstetrics, Southern Medical Center, Cairo, Illinois.

WIC Staff, Jackson County Health Department, Carbondale, Illinois.

Patricia Ryan, Director of Care Center of Springfield, Inc., Springfield, Illinois.

Jay Hodin, Executive Director, Society for the Protection of the Unborn Through Nutrition, Inc., Chicago, Illinois.

Karen Buchholz, R.D., Community Nutrition Chairperson, Mississippi Valley Dietetics Association, Davenport, Iowa.

HEARING OFFICERS

September 15, 1981

Representative Susan Catania
Representative Beverly Fawell
Joan Gaffney, R.D.
Virginia R. Hill
Jay Hodin
Alfred Klinger, M.D.
Beila Simon Kunis, R.D.
Dorice M. Narins, Ph.D.
Susan Palmore
Representative Peter P. Peters
Berna Satherlie Pollak
Germaine Rondoni

September 17, 1981

Arthur Blair
Senator Kenneth Buzbee
Sandra Eardley, R.D.
Jan Endres, Ph.D., R.D.
Virginia R. Hill
Patsy Jensen, R.D.
Dorice M. Narins, Ph.D.
Jeanne Wurtzinger, R.D.

September 29, 1981

Representative Susan Catania
Virginia R. Hill
Alfred Klinger, M.D.
Dorice M. Narins, Ph.D.
Representative Peter P. Peters
Berna Satherlie Pollak
Germaine Rondoni

SUMMARY

One of the most serious problems our nation faces today is that of teenage pregnancies. The United States ranks among the highest in the world for teenage birth rates, fourth among the developed countries. The Illinois Department of Public Health has recently estimated that in Illinois alone there will be 50,000 pregnant teens this year, and 30,000 of these girls will deliver their babies.

- Teenage pregnancy was responsible for 16% of the births, and it resulted in more than 20% of neonatal deaths (infants dying before reaching 28 days of age) and 30% of postnatal deaths (infants dying after 28 days of age but in their first year of life).

Higher risks of pre-eclampsia, toxemia, and anemia are just a few of the health problems associated with adolescent pregnancy, not to mention the economic and social consequences involved.

- In 1977-78, the maternal death rate among mothers under age 15 was 2½ times the rate among mothers aged 20-24.

- Teenage mothers were 15% more likely to suffer from toxemia, 92% more likely to have anemia, and 23% more likely to suffer from complications attendant on a premature birth than were mothers who gave birth at ages 20-24.

Pregnant teens also have a greater chance of having low birth weight babies (weighing less than 2500 grams or 5 lbs. 8 oz.). Low birth weight is associated with increased incidence of congenital abnormalities, neurologic defects, including

mental retardation, infant mortality, and a host of other serious childhood illnesses. Low birth weight is also a major cause of infant mortality, which is also a serious problem. Illinois ranks 7th in the United States, indicating only six states have higher infant mortality rates.

- The risk of death for babies born to teenage mothers is nearly two times greater than that of those born to mothers in their 20's. The problems of premature birth and low birth weight (less than 5.5 lbs) also occur more frequently among teenagers.

- Of the live births to teenage girls, 10% were of low birth weight, compared to only 6% for women 20 years and older.

One of the most important factors influencing pregnancy outcome and the health of the teenage mother and her infant is nutrition. Many of these teenagers have a poor nutritional status when they become pregnant, as well as during pregnancy, due to weight-reducing fad diets, skipping meals, eating high calorie/low nutrient snacks, and going to fast food places which offer little variety in foods. The nutritional needs are further increased when the adolescent is still going through physical growth and maturity during her pregnancy.

Because of the role nutrition plays in teenage pregnancies, the Illinois State Council on Nutrition held public hearings in Chicago on September 15 and in Carbondale on September 17, 1981, based on the fact that these areas have a high incidence of infant mortality. While recognizing the problem exists statewide, the need was more critical in the above two locations. Although the Council originally scheduled one hearing at each

location, an additional hearing was held in Chicago on September 29 due to the large response of people wishing to testify. The purpose of the hearings was to determine what nutritional problems are common in pregnant teens and the adequacy and accessibility of nutrition information and nutrition programs in Illinois.

The Chicago hearings were chaired by Representative Peter P. Peters, and the Carbondale hearing was chaired by Senator Kenneth Buzbee. Opening the hearings, Chairman Peters stated that teenage pregnancy has an enormous impact on society. The hospital costs for low birth weight children produced by high risk pregnancies are staggering. "The costs in terms of caring for children who are retarded or physically handicapped as a result of poor nutrition on the part of their mothers, teenage mothers in many instances, get to be staggering in terms of the dollars spent for lifetime care for these children," said Representative Peters. A study reported by the Harvard School of Public Health found that each dollar spent in the prenatal component of the United States Department of Agriculture's Women, Infants and Children (WIC) program saved three dollars in hospitalization costs due to the decrease in low birth weight infants.

"The Council is also very much concerned about the human factor and the human toll involved. The teenage mother undergoes a psychological and emotional trauma, and the child faces problems during its life through no fault of its own," said Representative Peters.

In dealing with the problems of teenage pregnancy, it must be remembered that teens are teens, first and foremost, pregnant

or not, and their diets reflect this. As one doctor testifying noted, "There is often some thought that because an adolescent is pregnant, she suddenly becomes an adult and has access to all of the wisdom implied by utilizing the term 'adult' rather than 'adolescent.' This is simply not true. Pregnant teens react exactly the same way as their non-pregnant counterparts and are subjected to exactly the same fads, likes, and dislikes. They see the same television programs, read the same newspapers, see the same billboards, and eat in the same fast food restaurants. They have little knowledge regarding nutrition, and this seems to be especially true in the area of minerals."

In the three days of hearings, 39 people testified, and several issues were identified.

1. Teens are teens, first and foremost, pregnant or not, and their diets reflect this. They have very poor diets. Deficiencies shown were iron, calcium, vitamins C and A, calories, and fiber. In some cases, intake of calories was excessive.

Specific nutrient deficiencies result from low income and/or poor nutritional habits of teenagers, combined with a lack of understanding of the increased needs during pregnancy and the relationship between good nutrition and (a) fewer complications during pregnancy and (b) a healthy infant.

2. Girls have little knowledge of nutrition and how it affects the course of pregnancy and the unborn baby.

3. The school lunch program is not sufficiently accessible to pregnant teens and does not supply enough food to meet their needs.

4. Many girls fall through the cracks. Either there were no programs available to them, or they had no knowledge of where to find the programs.

5. Those involved in the education of the teenager and those working with them during pregnancy need updating in nutrition in order to deal with the problem.

6. While the original purpose was not to determine the role of sex education, per se, testimony quickly pointed out that a course on parenting, responsibility education, human sexuality, and self-image is needed in the schools.

In the following pages, the issues are identified with supporting testimony. Transcripts of oral and written testimony are on file in the Council office. Anyone wishing to read the complete testimony can do so in the Council office. Since there are 457 pages of testimony, it is not feasible to send out copies. Additional testimony on statistics regarding the problem of teenage pregnancy in Illinois and on behavior patterns of teens is included in the Appendix.

ISSUE I

Evidence from nutrition surveys suggests the diets of teens are deficient. Teens are teens, first and foremost, pregnant or not, and their diets reflect this; they have very poor diets.

Specific nutrient deficiencies result from low income and/or poor nutritional habits of teenagers, combined with a lack of understanding of the increased needs during pregnancy and the relationship between good nutrition and (a) fewer complications during pregnancy and (b) a healthy infant.

FINDING A

NUTRIENTS FREQUENTLY MENTIONED SPECIFICALLY AS LOW IN THE DIET ARE: CALCIUM, IRON, VITAMIN C, VITAMIN A, CALORIES, AND FIBER. CALORIC INTAKE MAY ALSO BE EXCESSIVE IN SOME CASES.

Testimony

- "The most frequent nutritional inadequacies identified at the Adolescent Family Center are poor intakes of calcium, iron, vitamin A, and vitamin C." (Nickola)
- "The more frequent deficient nutrients in the pregnant teenager's diet that I have observed are calcium, iron, vitamin C, vitamin A, and folic acid. Low protein intakes are usually secondary to inadequate dietary intakes." (Garrick)
- "Anemic, inadequate nutritional patterns, obesity, abnormal patterns of pregnancy weight gain, caesarean section, short inter-conceptional period, and the majority of prenatal adolescents have not been referred by a physician to see a nutritionist until their third trimester of pregnancy. Teenagers need to be encouraged to drink more milk and juice. Many girls during their pregnancy are worried about their weight gain, especially those who have had a weight problem before becoming pregnant." (Johnson)

- "Most teenagers show a surprising lack of knowledge about the role of nutrition in safeguarding against prenatal complications. They don't realize that their baby is completely dependent upon the food they eat.... Nor are they aware of the importance of nutrition for their own health during their pregnancy." (Johnson)
- "(Some) teenagers seem to not to want to gain any weight during their pregnancy. They are not aware of the relationship between adequate weight gain during pregnancy and the pregnancy outcome. On the other hand, some teenagers seem to gain an excessive amount of weight during their pregnancy. This may be due to a lack of knowledge of proper dietary habits and extension of prior eating habits and just lack of prenatal (nutrition) education." (Rowland)
- "The most common nutritional deficits we have found are primarily milk deficient diets and secondly diets lacking fruits and vegetables. In general, the women eat sufficient amounts of meats, fats, breads, and cereals." (Braunling-McMorrow)
- "In the current active caseload of Illinois WIC pregnant teens, the most common risks exhibited, in order of frequency, are: inadequate nutritional pattern, (iron deficiency) anemia, and abnormal pregnancy weight gain. These are the most frequent risks identified in our teenage WIC population throughout the state. Downstate, the next most common nutritional risks identified include cigarette smoking and short interconceptual period. In Chicago, the next most frequent risks identified in teens include short interconceptual period, obesity or underweight at time of conception, and history of miscarriage/stillborn or abortion." (Maass)
- "In the past 2½ years of operation, the Center (Adolescent Health Center, Carbondale) has served 112 prenatal patients.... Of the 112 prenatal patients, a staggering 36.6 percent were anemic in contrast to the national average of 11 percent of pregnant teens being anemic. Only 6.1 percent of non-prenatal patients were anemic...." (Isberner)
- "... the general awareness about the importance of sound nutritional habits is probably close to zero and really only becomes important when a teen is upset about a weight problem." (Isberner)
- "Both students were told they were anemic and low in ascorbic acid.... Both students were concerned about their weight before, during, and after pregnancy." (Hicks)
- "Based on the Popras Risk Assessment Scoring System, which were used to follow each pregnancy, a full 75% of our patients were considered to have high risk pregnancies." (Setchfield)

- "In our population, the major nutritional problems encountered are: (1) lack of information, (2) smoking, (3) obesity, (4) poor dentition, (5) diets low in residue and high in carbohydrates, and (6) iron deficiency." (Setchfield)
- "Most of the clients (90%) have blood counts below the WIC standards for anemia. Abnormal weight gain pattern is the second most common nutritional problem seen in the pregnant teens we provide services to. The majority exhibit inadequate weight gain. Approximately 15% exhibit excessive weight gain. Analysis of our caseload revealed that all of the patients who had poor pregnancy outcomes exhibited one or a combination of the following nutritional problems: (1) inadequate weight gain (less than 10 pounds at 28-32 weeks gestation), (2) anemia with hemoglobin levels approximately 9.8-10.0 and hematocrit levels 29%-30%, and (3) excessive weight gain. The pregnancy outcomes for these clients included births to prematures weighing 2 lbs. 8 oz. and 4 lbs. and 7 oz., spontaneous abortions, and stillbirths. These clients ranged between the ages of 12 and 15." (Fleming)
- "... their diets lack important calories, protein, and iron. Ever conscious of their figures, these young girls often 'fast' or try bizarre fad diets after going on 'binges.' In addition, the adolescent client appears reluctant to gain weight, in comparison to her adult counterpart." (Murray)
- "Talking to a local nutritionist, she says that the two biggest nutritional problems are malnutrition and (iron deficiency) anemia." (Williams)
- "In addition, these girls often have a poor self-image when they begin the program. They do not seem to care about their own bodies. However, they do want to produce a healthy baby, whether they plan to keep the baby or not." (Barushok)
- "The students are ridden with hidden feelings about their pregnancies and, very often, the knowledge of the fact that the termination of the pregnancy will produce an infant who is going to be directly affected by their food intake during the pregnancy has not been assimilated. Furthermore, there is little consideration of how this pregnancy is going to affect their own babies." (Herron)
- "My impression was that the young mothers really just weren't tuned in to either their baby's health, or their own actually, in a lot of cases." (Ogintz)
- "I question whether the present state of knowledge of nutrition of the pregnant teenager or her knowledge about factors that affect the health of her baby are sufficient to allow her to make rational health decisions." (Taif)

- "Many teenagers come to their mothers for nutritional advice, mothers who delivered during the time when restrictive diets were commonly recommended during pregnancy." (Garrick)
- "The revised caloric guidelines for the school lunch program and the allowed substitutions will make it increasingly difficult for adolescents to meet even the bare requirements needed for a healthy growing baby and mother." (Sherline)
- "... most of them are anemic. They are obese. They have, most of them have, inadequate weight gain in pregnancy. The intake of iron, minerals, vitamins, and vitamin C is also low." (Johnson)

FINDING B

HIGH CARBOHYDRATE, LOW FIBER DIETS, WHICH ARE ALSO HIGH CALORIE/LOW NUTRIENT FOODS, CONTRIBUTE TO POOR NUTRITIONAL STATUS.

Testimony

- "The majority of the adolescents snack on high calorie, low nutrient dense foods." (Nickola)
- "Most adolescents consume food of high calories and low nutrient value. Teenagers are snackers and very seldom consume a balanced meal." (Johnson)
- "Many pregnant students eat filler foods, too much fried foods, heavy salt and sugar intake, pastas, and too little protein, too little fiber, too little minerals and iron-enriched foods." (Williams)
- "In our population, the major nutritional problems encountered are ... diets low in residue and high in carbohydrates." (Setchfield)
- "... and they (adolescents) consequently replace meals with high caloric, low density snacks such as chips, candy, cookies, and sweetened snacks." (Garrick)
- "A large proportion of their food comes from potato chips, pretzels, french fries, and candy. Also, the intake of vegetables and milk products is also low." (Johnson)

FINDING C

POOR DENTAL HYGIENE AND DENTAL CARIES ALSO CONTRIBUTE TO POOR NUTRITIONAL STATUS.

Testimony

- "In our population, the major nutritional problems encountered are: ... (4) poor oral hygiene and dentition." (Setchfield)

FINDING D

SMOKING AND/OR USE OF ALCOHOL OR DRUGS ARE FACTORS WHICH CONTRIBUTE TO POOR NUTRITIONAL STATUS.

Testimony

- "Peer pressure to indulge in 'fun' foods and other poor health practices, such as smoking, drinking, and drugs, makes the teen at higher risk and makes nutrition counseling more complicated." (Murray)
- "Alcohol, use of tobacco, and marijuana are believed to be the most often abused substances. 'Speed' and cocaine are occasionally suspected." (Connell)
- "Problems of alcohol, drugs, and smoking exist." (Hicks)
- "Investigations of drinking among teenage pregnants in the Chicago public schools indicates that it is a very minor problem. 'Pot' or marijuana smoking is a more serious problem." (Jones)
- "Alcohol consumption among teenagers, despite frequent statistics to the contrary, rarely is reported in the nutritional histories. Smoking, including marijuana, is reported more frequently." (Garrick)
- "Use of alcohol, cigarettes, or street drugs are rarely reported." (Nickola)
- "Alcohol and drug abuse have been really only infrequently encountered." (Setchfield)

- "She often smokes heavily and frequently takes alcohol and drugs." (Michelin)
- "The majority of clients enrolled in our program do not use hard drugs nor are they alcoholics." (Sherline)

FINDING E

GIRLS ARE OFTEN SEEN LATE IN PREGNANCY WHEN IT IS DIFFICULT TO DO ANYTHING ABOUT IMPROVING NUTRITIONAL STATUS.

Testimony

- "Many pregnant teens presently do not seek medical care until the 2nd or 3rd trimester, and several have presented at the hospital (in labor) with no prenatal care ever. The reasons often given are: no money ...; didn't want anyone to know they were pregnant; didn't know prenatal care was important to pregnancy outcome; didn't know where to go for prenatal care; and didn't know about various supports...." (Shupe)
- "Also, most teenagers are not seen by the nutritionist until their 3rd trimester, and several are expecting any day. Most of them only visited the physician once or twice." (Johnson)
- "(In Franklin and Williamson counties) of those receiving prenatal care, 127 were seen during the first trimester, 111 in the second (trimester), and 28 (pregnant teenagers) received no care until the third trimester. A few of the teenagers had no prenatal visits, 82 had between 1-5, and the most had 6-10." (Rowland)
- "Nutrition intervention is routinely begun at the first prenatal visit, at which the average gestational age is 20 weeks." (Nickola)
- "Both students waited until the third or fourth month to go to the doctor ... they had difficulty accepting ... it could happen to me." (Hicks)
- "Many of my students, about 50%, enter during their second trimester; about 47% enter during their last trimester; and about 3% enter in their first trimester--around the third month--never before." (Williams)

- "A girl is usually three to four months pregnant when she comes to our program." (Barushok)
- "Another problem is that our students are generally in the middle of the second trimester of their pregnancies when they enroll." (Herron)
- "We typically see the pregnant girls at the mid-stage of the second trimester or at about 4½ months." (Jones)
- "Seven in ten teenage mothers under age 15 ... and 3% of teenagers 15 to 17 years of age receive no prenatal care during pregnancy." (Maskay)
- "It is not uncommon for us to have our first contact with a teen when she is eight or nine months pregnant." (Michelin)

FINDING F

POOR EATING PATTERNS, SUCH AS SKIPPING MEALS
AND RESTRICTIVE DIETS WHICH CONTRIBUTE TO
IMPROPER WEIGHT GAIN, CONTRIBUTE TO POOR
NUTRITIONAL STATUS.

Testimony

- "Many girls during their pregnancy are worried about their weight gain, especially those who have had a weight problem before becoming pregnant, and because of their weight gain, reduce their intake to one meal per day." (Johnson)
- "Fifty percent of our clients do skip meals, with breakfast and lunch being skipped most often." (Nickola)
- "Teenagers often have irregular eating patterns, and they frequently replace meals with high caloric, low density snacks such as chips, candy, cookies, and sweetened beverages." (Garrick)
- "Most low socioeconomic groups average fewer breakfasts and lunches than their more affluent peers." (Johnson)
- "The missed breakfast is the biggest problem I encountered in both the pregnant and non-pregnant students. I will often send to the cafeteria for milk if the pregnant student is complaining of feeling dizzy and weak, especially if they admit to skipping breakfast." (Connell)

- "A few physicians in the area still seem to follow the old practice of restricting their (pregnant women's) weight gain." (Rowland)
- "On my initial visit to her home, I began going through a health history with her. I asked her pre-pregnancy weight. She quoted me 118 pounds. This took me back somewhat because it was quite evident that the 5' 1", 17-year-old was much heavier. I asked for her present weight, and she quoted me 171 pounds (a 53 pound weight gain)." (Bennett)
- "... the primary problems seem to be the availability of fast food, irregular intake, skipping breakfast, and infrequent family meals." (Isberner)
- "The majority of pregnant adolescents I see indulge in fast foods, high calorie/low nutrition snacks, and routinely skip meals. Consequently, their diets lack important calories, protein, and iron. Ever conscious of their figures, these young girls often 'fast' or try bizarre fad diets after going on 'binges.'" (Murray)
- "They eat a lot of junk food." (Ogintz)
- "So, sometimes I think it's a matter for them of eating at all, much less eating what they ought to be eating, or even aware of what they ought to be eating." (Ogintz)
- "This is the time we find her (the pregnant adolescent) unable to eat, purposely to avoid getting fat." (Michelin)

FINDING G

OTHER MEMBERS OF A FAMILY ARE OFTEN GIVEN FOOD
INTENDED FOR THE PREGNANT TEEN.

Testimony

- "Younger family members in the household are often given priority access to foods like milk or juice (thus depriving the pregnant teen of sources of calcium, protein, and vitamins). They (teenagers) often have limited input as to what specific foods are prepared at home or purchased. Such stress (emotional) may be reflected in her eating patterns." (Garrick)
- "The majority of the clients report sharing the foods received (from WIC) with other family members." (Nickola)
- "It is difficult not to share this food (WIC supplements) with other members of the family...." (Sherline)

FINDING H

IMPROVEMENT OF THE OUTCOME OF PREGNANCY IS POSSIBLE IF NUTRITION IS ADEQUATE.

Testimony

- "Data obtained from 204 postpartum adolescents showed improvements in weight gain from an average of 20.7 pounds to 27.9 pounds (the recommendation of the American Academy of Obstetrics and Gynecology for adult women) and birth weight from 6 pounds 12-4/5 ounces to 7 pounds 12-4/5 ounces. The rate of low birth weight decreased from 18.1% to 6.3%." (Nickola)
- "In the two years that ... program has been operating, none of the women have delivered low birth weight or otherwise developmentally abnormal infants. Although we cannot justifiably state that this has been a direct result of our program, this data is certainly worth mentioning." (Braunling-McMorrow)
- "Fiscal Year 80-81, we recorded 112 live births. Thirty-seven percent were to moms under 20, 32% unmarried, 3% premature/low birth weight, 2% caesarean section, and a 1% toxemia rate." (Shupe)
- "Based on the Popras Risk Assessment Scoring System, which were used to follow each pregnancy, a full 75% of our patients were considered to have high risk pregnancies. In this same group of patients, there were no intrauterine deaths. Only 3% had either premature deliveries or low birth weight infants; less than 1% developed pre-eclampsia. There were no incidences of eclampsia; and only 2% required either repeat or primary caesarean section.... Less than 5% had clinical anemia at the time of delivery. One of the major reasons for this successful outcome that these numbers illustrate is the constant attention given to the area of nutrition." (Setchfield)
- "So far, about 7-10 girls have given birth to babies 8 pounds or over. However, the mean weight is about 6.5 pounds. Yet, there is still a large percentage ... about one in every six girls, who give birth to babies 5 pounds and under." (Williams)
- "Chicago has the second highest infant mortality rates in the United States at 24.2. Our Booth Hospital statistics, in comparison, is 9.0, and this is outstanding when you consider the majority of our clients are 17 years and under." (Barushok)

-- "... a release of the U.S.D.A. has reported reduction of infant mortality together with the introduction of WIC. They have recorded reduction of anemia ... in WIC participants and they have also reported reduction in numbers of low birth weight infants that are born to WIC women."
(Taif)

ISSUE II

It has been stated that girls have little knowledge of nutrition and how it affects the unborn baby.

FINDING

THE IMPORTANCE OF NUTRITION EDUCATION EARLY WAS RECOMMENDED OVER AND OVER. TEENAGERS KNOW VERY LITTLE ABOUT NUTRITION IN GENERAL, MUCH LESS ABOUT THE IMPORTANCE OF NUTRITION DURING PREGNANCY. MOST THINK IT IS DULL AND THAT IT HAS LITTLE TO DO WITH THEM. VERY LITTLE NUTRITION IS TAUGHT IN THE SCHOOLS. IF A HIGH SCHOOL COURSE IS OFFERED, THE PREGNANT TEEN HAS NOT BEEN EXPOSED OR HAS DROPPED OUT BEFORE TAKING IT.

Some of the specifics of the finding are as follows. Nutrition information is not readily available, is not taught soon enough, and is fragmented at best. Teens do not see the need, and nutrition courses are all elective except health. Health courses may or may not include nutrition. (Note: See Statistics in the Appendix)

The information they do get may be inaccurate or misleading. Pregnant teens not only need nutrition education but basic buying and cooking skills. The extremes would not be practiced if the teens had better knowledge of proper diets for them. Nutrition education must start early in the elementary grades if it is to be effective when the teens need it most.

Testimony

- "Teenagers are also ill equipped to analyze and process the confused nutritional messages provided by the media, their peers, and their families. Nutrition education is spotty and is not always provided adequately to young people. Special programs for pregnant teenagers, some clinics, and health care facilities do provide education regarding prenatal and infant nutrition, but the contact is limited to a few sessions which are not adequate to combat years of nutritional misinformation and/or ignorance. As a result, the pregnant teenager and the teenage mother do not have the nutritional literacy or the necessary skills to make sound nutritional judgments and to juggle limited resources to best meet their own as well as their infants' needs." (Maskay)
- "Many teenagers do not receive any nutrition education in school, and then when they become pregnant, they still do not receive any unless they are participating in a nutrition program. If nutrition education was taught in the grade school and in early junior high, this would be an advantage to many adolescents. Education in the school system must be started early, because 13 and 14 year old girls are now becoming pregnant, and they need this education. Basic nutrition, prenatal nutrition, and possibly infant nutrition would give many teenagers a greater understanding of nutrition and its importance to health and growth and development." (Rowland)
- "How is nutrition information being made available? The scenario goes like this. There are too few of us doing 'something' with so many of them not getting that 'something.' The reasons are many. The question might be asked, 'Do adolescents see the need?' The situation as it exists is that nutrition education is covered ever so lightly in the elementary grades. There is no mandate on teaching nutrition, and even if there was, few teachers are adequately prepared to do an effective job. At the secondary level, health is required of ninth graders. The physical education department is responsible for the instruction. The instructor told me he spent five to seven hours on the subject. Where else does the student get nutrition information? Home Economics Orientation, Foods and Nutrition, and Child Development, all of which are electives." (Hicks)
- "Of the major nutritional problems that we can detect during this prenatal care, probably first and foremost is a lack of information." (Setchfield)
- "Recommendations for improving teenagers' dietary practices are: ... continued and expanded nutrition education on all grade levels as behavior patterns of teenagers are founded in the formative years." (Isberner)

- "In terms of providing nutrition education specifically designed for the pregnant adolescent, our schools are offering very little, if any, services. Our area contains 15 school districts. In a recent survey, seven responded to a questionnaire. When asked if nutrition education is taught in the school, all seven answered by saying that the subject is discussed as a part of home economics, health, or physical education classes. However, all seven responded that they offered no specialized teaching for the pregnant teenager. If the girl happened to be enrolled in the course offering nutrition education, she would receive the information. In other words, it is a very haphazard, inefficient process." (Hill)

- "Because today's youth are so poorly educated in nutrition, they relate weight gain to quantity rather than quality of what they eat. So, at the time when nutritional intake is at its most important stage in terms of fetus development, the teen mother is literally starving herself and her baby. What the mother does not realize is that she is not affecting her own weight as much as she is that of her baby's. If either of the two is losing weight, it is the fetus who so desperately needs its weight at this time for development and survival." (Bennett)

- "Many of the teenagers are not interested in questions pertaining to their eating habits because they are not aware of the relationship between their diet and their pregnancy outcome. This is one important part of nutritional counseling that must be stressed to the pregnant adolescent." (Rowland)

- "Some teenagers seem to gain an excessive amount of weight during their pregnancy. This may be due to a lack of knowledge of proper dietary habits, an extension of prior eating habits, and just lack of prenatal nutrition education." (Rowland)

- "If nutrition education could be given when applying for food stamps, this would also benefit many teenage pregnancies." (Rowland)

- "There is no formal education in nutrition specifically for the pregnant students. There are some classes that offer basic nutrition to all students, and the nurse lectures also to the general student population." (Connell)

- "The two most common reasons for poor nutrition (that) clients offer are (1) limited access to quality foods due to inadequate income and (2) inadequate knowledge of the relationship between nutrition and pregnancy outcome. If this is true, it seems reasonable to assume that increasing the availability of quality foods would produce better pregnancy outcomes in pregnant teens." (Fleming)

- "Availability of sound nutrition education for teenagers and pregnant teenagers in particular is spotty at best. Special programs for pregnant teenagers, and some clinics and health care facilities provide education in prenatal and infant nutrition. However, the contact is limited, and many years of misinformation and lack of nutrition literacy must be combated in a few brief sessions. The nutritional needs of the lactating mother, infant, and child nutrition generally receive scant attention. The teenager grapples with the misinformation of her family and her peers, and frequently encounters difficulty in implementing newly learned nutritional concepts. The mass media messages and new foods on the market make good judgment regarding nutrition even more difficult." (Hinds)
- "Educating the pregnant teen is one of the greatest challenges I face as a public health nutritionist. The nutritional management of the pregnant woman is the primary determinant insuring a well-nourished, healthy infant. The pregnant adolescent presents a unique problem in that the nutritional stress of pregnancy may be superimposed on the teenager. The teen, of course, is still growing and maturing, and may already be poorly nourished." (Murray)
- "It has been my experience that the pregnant teen is not aware of the important role nutrition plays throughout the life cycle, let alone its primary importance during pregnancy. She is often misled by well-meaning family or friends into following potentially dangerous meal patterns. Peer pressure to indulge in 'fun' foods and other poor health practices, such as smoking, drinking, and drugs, makes the teen at higher risk and makes nutrition counseling more complicated." (Murray)
- "In educating the pregnant teen, more emphasis is needed on the practical areas of food budgeting and cooking skills for better compliance. Making nutrition education mandatory in schools would be the best approach in dealing with the majority of these problems." (Murray)
- "Last year when we had a nutrition education program in operation ..., we discovered that our girls had far more basic information about what is good for them than we would ever have thought. What we found was that the information on nutrition, as with most everything else they have learned, was not seen as information that they needed personally in their daily lives. They did not in any way impact the information upon themselves. Therefore, anything we do in the future must have as the primary goal the changing of attitudes." (Herron)

- "Whatever we can bring to the public and to the (medical) profession in terms of (nutrition) education is worthwhile. ... dietary fads probably are more prevalent, in a way, among the upper income groups than they are among the lower, because the lower do not have the luxury to involve themselves in such fads, and this should be called to their attention. However, I would remind you that using such perimeters as prematurity toxemia, all related to inadequate dietary intake, is three to four times the incidence in the lower socioeconomic groups than they are in the upper. So, indeed, poverty does play an important role to educate the fatuous, if you will. It would be extremely difficult to bring the level of education that we deem optimal to every obstetrician and family practitioner's office who is involved with prenatal care--and for that matter, certified midwives, certified nurse practitioners. This can be attempted, and I hope successfully done, but those mechanisms are in place. The water is there, the horse must drink." (Barton)
- "It is not easy to arouse an adolescent's interest in diet and nutrition because the word 'nutrition' often connotes a boring subject to her. Since eating is a habit, pregnant teenagers have probably not given much thought to it, and they need to be motivated to change. In addition, these girls often have a poor self-image when they are pregnant, and they do not seem to care about their own bodies." (Hill)
- "The general awareness about the importance of sound nutritional habits is probably close to zero and really only becomes important when a teen is upset about a weight problem." (Isberner)
- "I question whether the present state of knowledge of nutrition of the pregnant teenager or her knowledge about factors that affect the health of her baby are sufficient to allow her to make rational health decisions. So, what must we do to close these critical gaps? I would say our primary line of action would be intensified information in the schools. Intensified sources with all health providers, whether they be private or public, and to encourage more information throughout the media so that the three groups can be joined together to see that adequate and accurate information does get to the teenager. But if we were to take the primary initiative, I would say direct it in the schools through increased family life and nutrition education." (Taif)
- "A study reported by the Harvard School of Public Health found that each one dollar spent in the prenatal components of the WIC program saved three dollars in hospitalization costs due to the decrease in low birth weight infants. So, when we speak of programs for nutrition education and services, we really must address the issue of how many dollars are we willing to spend for preventative programs, and I would hope that the bottom line will not bring us to a still-born conclusion." (Taif)

- "I would say my major focus would be on education--nutrition education. I realize that many of these teenagers drop out of school, so that education in the schools, although extremely important, will not necessarily reach all of these children. This is why I had felt that it had to take a number of us working together, not only the schools, looking very carefully at their curriculum. Do they include nutrition education, particularly for the teens? But, of course, I'm the one who feels that nutrition education should have started in the primary grades, not waiting until they become a teenager. I think there has to be an examination of the curricula in schools." (Taif)
- "The educational environment that a school provides me with has a huge need to develop more esteem and awareness of a girl's needs. Classrooms do provide captive audiences for regularly scheduled time periods. The classroom allows for greater feedback from students. This assists me in adjusting my services to meet the teen with a specific need. Being within a school physically provides me with a means to establish rapport more easily and quickly just by having students in familiar surroundings and among friends." (Garrick)
- "Adequate nutrition information is not available to the teenager." (Garrick)
- "I have no objection to vitamin and mineral supplements provided it's not in place of good education and good nutrition and the hope we can cure it by giving someone a pill to take." (Michelin)
- "Increased nutrition information must be made available in a palatable form to students beginning at an early age and continued in a repeated fashion through high school. This information must contain not only information regarding what to eat and not to eat, but also methods of preparation that preserve nutrient values present in the foods our clients are able to eat." (Sherline)
- "Basic nutrition information should be required as a part of elementary curriculum and expanded nutrition emphasis required at the secondary level as well." (Hicks)
- "The adolescents are not fully educated of the importance of nutrition. They have inadequate nutritional patterns. Most adolescents consume foods of high calorie content but (that) have low nutrient value." (Johnson)
- "I feel like if we could have nutrition programs in the schools that would also help. I feel that it is just out of the 7th grade level we should have home economics. In high school, I figure that should be a required course." (Johnson)
- "Nutrition education should be an integral part of health education in schools and should be designed to teach at an early age the skill to analyze and process available information in order to make sound nutritional decisions." (Maskay)

ISSUE III

It was assumed that the School Lunch Program was sufficiently accessible to pregnant teens and did supply enough food to meet their needs.

FINDING

THE SCHOOL LUNCH PROGRAM IS ONE PLACE WHERE PREGNANT TEENS SHOULD GET AN ADEQUATE, BALANCED DIET. THE PORTIONS OFFERED EVEN IN THE ALTERNATIVE SCHOOLS WERE GEARED TO 12 YEAR OLDS. THEY WERE NOT GEARED TO THE NEEDS OF A GROWING ADOLESCENT WHO WAS PREGNANT. AS GOOD AS THE WIC PROGRAM IS, ONLY A VERY SMALL PERCENT OF GIRLS ARE ON WIC.

Testimony

- "The school lunch and breakfast programs illustrate the problem well. They are inadequate to meet the increased nutritional demands of the pregnant adolescent for energy and almost all the nutrients. This is true of the meals provided both at special schools for pregnant teenagers as well as in regular schools. The lack of recognition of their increased needs has long-range effects. The adolescents concerned see it as hypocritical, that whereas they are being taught the importance of nutrition, their school does not concern itself with their increased nutritional needs. They also relieve their hunger with foods like candy, potato chips, pop, and other nutritionally inadequate foods. Considering that these young women are in school for 7-8 hours, that is one-half of their waking hours, it is impossible for them to meet their daily requirements for nutrients with the meals provided. This sets a poor example to them, besides undermining nutrition and health education being given." (Maskay)
- "But an avenue that I feel should not be overlooked in the schools is the access to a school lunch program that must be flexible enough to meet the pregnant teen's needs. The school lunch program, as I understand it, today is really designed for a very young child--certainly a child who is

not pregnant. I am not saying that the school lunch should be brought up to the level of all students to meet the pregnant teens', but I think there should be a flexibility in that lunch so that the pregnant teen can secure, without excessive cost to her, what she needs." (Taif)

- "Even with all this 'good stuff,' our program is grossly inadequate in terms of nutrition. We can provide the information, but if the actual food is not available, what have we done? The school lunch is a typical type A school lunch. It has just been recently that all of the students in those programs were made eligible for the WIC program services. I'm still not sure if this means that any girl who is pregnant is eligible, or if only those in the special programs are eligible. In my opinion, any teenager who is pregnant should be eligible. Now, back to the school lunch program. Not only are there no extras in terms of protein, milk products, and fresh fruits and vegetables, all of the students are not even eligible for the free lunch. Only those students whose family incomes are within the allowable limits are provided free lunch and breakfast. So, you see, we can only teach, educate, talk, but we can't provide, that two-thirds of the day that the student is with us, we can't provide for them in terms of food intake. We can give them the information, but we cannot always back it up. In terms of daily food requirements of pregnant adolescents, those students who eat breakfast and lunch at school are not getting two-thirds of what they need, since our lunch program is not designed for pregnant girls. At this time, I am not aware of any plans to change that. If there are any plans in the making, I'm not aware of them." (Herron)
- "... it appears to be economically and socially foolish to save a few dollars by having a standard or sub-standard lunch program for teenage pregnant girls and the small investment that will be put toward improving more than the lunch that's available.... This investment will pay many times over in terms of improving maternal and child health." (Hodin)
- "I would also include the National School Lunch Act and Child Nutrition Act as positive forces for good nutrition. With these, we know the students have access to two well-balanced, nutritious meals daily." (Hicks)
- "Recommendations for improving teenagers' dietary practices are: ... supporting school lunch programs in providing meals attractive to the teenage lifestyle that are also balanced and high in nutritional value." (Isberner)

- "A good nutrition education program should give the adolescent concrete experience in planning, preparing, and learning to like good foods. One area that could be explored is the school lunch program. A specialized lunch program could be established for pregnant teens to meet their increased nutritional needs." (Hill)
- "The school lunch and breakfast programs provided at most schools are extremely inadequate and do not meet the increased nutritional demands of the pregnant teen for energy or any of the major nutrients. This kind of inadequacy can result in serious malnutrition which is bound to have a negative effect on pregnancy outcome." (Hinds)
- "The Caucus would like to make the following recommendations in this regard: ... supplement school lunches and provide breakfasts in special school programs for pregnant girls." (Hinds)
- "Presently, many adolescent pregnant girls qualify for the free breakfast and lunch program. This program does not provide a special breakfast or lunch for pregnant girls, nor does it include all pregnant girls as qualified. They must meet the same family income qualifications as the other students. Efforts in the immediate past to make all pregnant girls eligible for the free lunch and breakfast program and to provide additional or special nutritional content to these meals have been futile." (Jones)
- "Recommendations continue to press to-- Include all pregnant girls as eligible for free lunch ... Request special breakfasts and lunches for adolescent pregnant girls in all schools, including the alternative high schools for pregnant girls." (Jones)
- "The school breakfast and lunch program providing free and reduced price meals for our students is a vital, basic part of the program. Although the lunch is not adequate for pregnant students--we receive the regular high school lunch with no protein and other supplements which are known to be necessary for pregnant girls--it is far better than no school lunch. Free lunch should be provided for all school-age pregnant girls regardless of family income for the following reasons: (1) Teen pregnancies are all classified as 'high risk.' (2) The girls thrive on 'junk' foods and would not select basic necessary nutrients if left alone to select their breakfast and lunch foods. (3) The costs of basic meals is often prohibitive for students in low to poverty level income families." (Green)
- "The biggest problem that I deal with ... is the skipped breakfast." (Connell)

- "With the school breakfast and lunch program, we found that with our clients, 40% of them are eligible for the school breakfast and 25% of them are actually eating it. They felt that it is served too early, so they're not taking advantage of it." (Nickola)
- "We find that 80% are eligible for school lunch, and we found that 70% are eating it." (Nickola)
- "If the increased nutritional requirements due to both factors (growth spurt of mother and fetus) are not met, both the fetus and mother may suffer. Sub-optimal nutrition during pregnancy may cause the development of other complications such as anemia and hypertension." (Hinds)
- "The majority of pregnant adolescents I see indulge in fast foods, high calorie/low nutrition snacks, and routinely skip meals. Consequently, their diets lack important calories, protein, and iron. Ever conscious of their figures, these young girls often 'fast' or try bizarre fad diets after going on 'binges.' In addition, the adolescent client appears reluctant to gain weight, in comparison to her adult counterpart. These behavior patterns pose serious implications for the mother and the child." (Murray)
- "A large portion of the girls' total caloric intake appeared to be derived from snack foods such as soft drinks, potato chips, french fries, candy, ice cream, and other sweets. Intakes were characteristically low in vegetables, milk, and milk products. Their diets tended to be low in calcium, ascorbic acid, and iron. These findings were even more pronounced among those coming from poor homes. In attempts to limit caloric intake, many girls adopt bizarre dietary patterns which result not only in severely restricted caloric intake but also in seriously limited consumption of other nutrients so essential during physical maturation." (Barushok)
- "I've had students at Arts of Living complain about soup. It is inedible overall, and it is really a shame, with the need for a balanced school lunch, (for it to be) complicated by inability (to eat) and huge plate waste." (Garrick)
- "In summary, adequate supplemental foods must be provided to bring the required caloric intake to normal for pregnancy (approximately 2300 calories per day)." (Sherline)
- "They receive a school lunch and, sometimes, a donut. While I am not personally in the lunch (program), portion sizes are small, the diet is inadequate." (Garrick)
- "Inaccessibility to nutritional foods in both quantity and quality is foremost." (Garrick)

- "My impression was that the young mothers really just weren't tuned in to either their baby's health or their own, actually, in a lot of cases. And the one thing I'll say is most of the pregnant girls and the mothers that I interviewed are extremely poor. So, sometimes I think it's a matter for them of eating at all, much less eating what they ought to be eating, or even being aware of what they ought to be eating." (Ogintz)
- "The (WIC) caseload of pregnant adolescents (aged 18 years or less) is 2,309, or 20% of the (total) caseload of pregnant women." (Maass)

ISSUE IV

We were told that many girls fall through the cracks. Either there are no programs available to them, or they have no knowledge of where to find the programs.

FINDING

PREGNANT TEENAGERS ARE NOT AWARE OF THE SERVICES AVAILABLE TO THEM, AND EVEN IF THEY ARE, THERE IS LIMITED ACCESS TO THE PROGRAMS DUE TO LACK OF TRANSPORTATION AND PERMISSION TO LEAVE SCHOOL. FEW SCHOOLS HAVE PROGRAMS FOR PREGNANT TEENS, AND EVEN MORE ALARMING, ON A STATEWIDE BASIS 80% OF PREGNANT TEENS DO NOT COMPLETE HIGH SCHOOL. OF THE 29,800 TEEN PREGNANCIES IN ILLINOIS, WIC'S CASELOAD WAS 2,309 AS OF AUGUST, 1981. ONLY 20% OF TOTAL WIC CLIENTS ARE PREGNANT TEENS.

Testimony

-- "... the WIC program has been designed as an agent to health care. It does couple nutrition aid cases with supplemental foods that provide not only calories and protein, but emphasize foods that are necessary for the normal health, and even other needed nutrients. And the pregnancy alone gives the teenager high priority for WIC eligibility. But, unfortunately, the pregnant teen has had limited access to the WIC program in the City of Chicago and elsewhere in the State. The WIC program is not a city-wide program, nor is it a state-wide program. The Chicago Department of Health was able, in just a small area last year, to surround this residency barrier and to take the WIC program into four of the alternative schools for pregnant teenagers in 1981 ... but even those who attended these four schools are only a portion of pregnant teens in the City of Chicago." (Taif)

- "For young women seeking care through Crossroads, nutritional counseling is available; however, problems arise in obtaining further help. Although we have a WIC program in the area, accessibility is always difficult. ... we have no public transportation. Along with no evening hours, it makes it very difficult for many of our applicants to even apply." (Michelin)

- "But across the city and the state, ... many of the professionals involved said the teenagers simply aren't aware of the services available to them. And even worse, no one seems to be coordinating these programs. Several Chicago hospitals have special programs set up just for pregnant adolescents, but they reach only a handful of those who need help. One social worker at one of these programs likened her job to having half a finger in the dike. Rush, Presbyterian, St. Luke's has this special adolescent family center. Michael Reese has three programs, one just for girls under age 15. But Rush's program treats only 70 girls at a time, and all three Michael Reese programs reach only 60 girls a year. Administrators of both hospitals conceded that for every girl they treat, dozens are getting little or no care at all. Many girls, it seems--and they told me this--try to hide their pregnancies as long as they can. And once they have had their children, they simply get lost in the system and have very, very little follow-up care." (Ogintz)

- "There are four special high schools in Chicago for pregnant teenagers. Last year they operated on a \$1.7 million budget, but only 1,100 girls attend these programs at a time. There's always a waiting list, and school officials said that once these girls' babies are born, there's really no way to help them. They call it their 'weak link.' Of course, it should be realized that the kids reached, even in those prenatal programs--that's only the minority. Most girls just drop out of school altogether once they are pregnant, and then once they have their babies, Chicago school officials discovered in doing a study recently, that there is no infant care for them, so they can't get back to school--unless there's a relative around to take care of the children. I'm sure you are all aware that there's something like one spot in a day care center in the city for every ten children who need help. So, what many of these kids end up doing--and they are kids that clearly have a kid--is that they stay home and take care of their babies and watch a lot of soap operas." (Ogintz)

- "Consider that at Cook County Hospital where teenagers deliver more than 3,000 babies a year--that's 35% of all births--there's no special unit for teenage mothers." (Ogintz)

- "The schools are supposed to be able to do homebound education. The problem is the child drops out of school, and the school is no longer responsible for homebound education." (Ginther)

- "I think what needs to be done the most ... is that there has got to be a much better coordination of services in this city and across the state. I was surprised in researching ... this subject, at how much was available actually, ... but on the other side of it, the youngsters aren't aware of what's out there for them. And a lot of times even the professionals involved with one program or another didn't know what was going on somewhere else in the city or state." (Ogintz)

- "We find that 80% are eligible for school lunch, and we found that 70% are eating it. We also found that 95% of the clients are eligible for the WIC program, but by the time they come to us, we see they're 20 weeks pregnant and they're not on the program yet. Only 5% are on the program by the time they see us. So, it really is hard. Then, we can get them on the program, and maybe they're 25 weeks pregnant--30 weeks pregnant by the time they actually start reaching the WIC program." (Nickola)

- "The supplementary food program for Women, Infants and Children (WIC) has proven to improve the outcome of pregnancy. However, WIC does not appear to be reaching the many high risk pregnant women, based on the high infant mortality rate in Illinois. Whereas many health professionals are aware of the program, more outreach to the community is needed." (Murray)

- "Statistics indicate that in Chicago more than 12,000 teenagers get pregnant and go full term with the pregnancies. The four schools for pregnant girls in Chicago service approximately 1,800 of these children. Many of the students continue in their home schools, but I suspect the majority of them just drop out." (Herron)

- "I realize that many of these teenagers drop out of school, so that education in the schools, although extremely important, will not necessarily reach all of these children." (Taif)

- "... one of the problems is the student getting away from school. In the first place, they can get family planning and services without parent's permission, but they can't leave school without parent's permission, and the girls often try to forge notes...." (Connell)

ISSUE V

Many nutritionists are concerned that those involved in the education of the teenager and those working with them during pregnancy need basic nutrition and/or updating in order to deal with the problem.

FINDING

NUTRITION EDUCATION IS AN ONGOING NECESSITY FOR THOSE WORKING WITH PREGNANT ADOLESCENTS. PROFESSIONALS DO NOT ALWAYS HAVE THE TRAINING OR THE CURRENT INFORMATION PERTINENT TO THE PROBLEM. THESE PEOPLE DO NOT ALWAYS SEE THE NEED TO RELATE PROPER NUTRITION TO A SUCCESSFUL PREGNANCY.

Testimony

- "I question whether the present state of knowledge of nutrition of the pregnant teenager or her knowledge about factors that affect the health of her baby are sufficient to allow her to make rational health decisions. So, what must we do to close these critical gaps? I would say our primary line of action would be intensified information in the schools. Intensified sources with all health providers, whether they be private or public, and then to encourage more information throughout the media so that the three groups can be joined together to see that adequate and accurate information does get to the teenager. Secondary initiative should be directed to examination of printed nutrition information that is being made available to the health care provider and, in turn, to the pregnant teenagers." (Taif)

- "It is vitally important that the home economist, the physical education teacher, and the science teacher come together in a cooperative venture to accomplish this task." (Huntington)
- "School nurses have assumed the role of educator, counselor, and coordinator of services for the adolescent. Within the Division of Health Promotion and Screening is the School Health Section, which serves as the 'clearinghouse' and coordinator of school activities for the Department, as well as acting as liaison to other state and local agencies providing services to school children 3-21 years of age. Adolescent pregnancy is a priority for the School Health Section. In order to fully utilize the school nurses as nutrition educators, it is anticipated that the support and training provided by the School Health and Nutrition Services Sections will be closely integrated." (Maass)
- "... it would be extremely difficult to bring the level of education that we deem optimal to every obstetrician and family practitioner's office who is involved with prenatal care--and for that matter, certified midwives, certified nurse practitioners. This can be attempted, and I hope successfully done, but those mechanisms are in place. The water is there, the horse must drink." (Barton)
- "Much nutrition education should also take an important part in any prenatal care that is given. If more education could be given with a medical assessment at the physician's office, this would reach many more pregnant teenagers. Our program sends out small bulletins to area physicians explaining our program, its benefits, and how to refer patients to us. We also include some aspects of nutrition that we feel is of importance to us and to the physicians." (Rowland)
- "I think we also have to work in concert with all ... medical associates so that the information that the private health care provider distributes is accurate." (Taif)
- "I would think that heightening awareness is an important thing, making physicians more aware of the impact of daily nutrition on diseases we commonly run into. I think pregnancy is just a terrific example of that." (Setchfield)
- "... take steps to encourage physicians providing prenatal care to place more emphasis on nutrition. So many of my clients state to me that their physician says little to them in terms of nutrition. If the physician were to stress more importance on nutrition, perhaps the teen would take it more seriously." (Bennett)
- "... whatever we can bring to the public and to the (medical) profession in terms of education is worthwhile." (Barton)

- "March of Dimes has recently completed an assessment for the teaching of nutrition in medical schools; however, more needs to be done in this area, including frequent updates for nurses and other professionals." (Michelin)
- "Professionals, such as nurses, do not give adequate information as well as they should." (Michelin)
- "... it is not an educational process that begins and ends in medical school, or begins and ends in infancy. It's an educational process for all of us whether we be the individuals who are concerned with our own health, or the professionals who are concerned with the health of others ... we continue this educational process our entire life. That is critical." (Barton)
- "... it's true that I learn more and more from my patients than I learned in the medical school, because mostly what I got in medical school--and I still have it--is a sheet about one inch thick listing every known food in the world, I think, and what's in it. And that, primarily, was what I got taught about nutrition, and I was at a very good medical school." (Setchfield)

ISSUE VI

While it was not our original purpose to determine the role of sex education and teenagers, per se, it became very apparent a course on parenting, responsibility education, human sexuality, and self-image is needed in the schools.

FINDING

IN THE 1970'S, THE NUMBER OF SEXUALLY ACTIVE TEENAGERS INCREASED BY TWO-THIRDS. GIRLS ARE MATURING EARLIER, AND THE AVERAGE AGE FOR ONSET OF MENSTRUATION IS 12.7 YEARS. IN MANY CASES, THE TEENS WERE NOT AWARE OF WHAT WAS HAPPENING BIOLOGICALLY. TOO OFTEN IT IS THOUGHT BY THE TEEN THAT A BABY WILL BE FUN, A COMPANION, SOMEONE TO LOVE. BUT THE REALITY OF THE SITUATION COMES TOO LATE. STATISTICS INDICATE THAT (1) IF TRENDS CONTINUE, FOUR OUT OF EVERY TEN GIRLS WILL BECOME PREGNANT IN THEIR TEENS; (2) 86% OF THE PREGNANCIES THAT OCCUR TO UNMARRIED TEENS WERE UNINTENTIONAL; AND (3) A TEENAGE MOTHER, WITHOUT INTERVENTION, WILL BECOME PREGNANT AGAIN WITHIN TWO YEARS.

Testimony

-- "... when a million kids are getting pregnant a year, it needs to be talked about." (Herron)

- "Thus teenage pregnancy has, in the view of many, reached an epidemic proportion. The reasons for this are complex and include the lack of adequate sex education and lack of contraceptive services geared towards the adolescent." (Bennett)
- "It's my consideration that the problem of recurrent pregnancies among teenagers are major social problems that need more attention. Teenagers need family planning services and education to help fight the problem of unplanned pregnancies prior to conception. I recommend schools to teach sex education classes. Schools should offer not only sex education, but also its health implications and nutritional consequences." (Garrick)
- "During the school year, I was allowed to invite various agencies who were knowledgeable in sex education, family planning, VD, etc., to lecture in the classrooms. This first proved what we already suspected, the students lacked correct information about the listed subjects, they are not the 'cool cats' they act like they are. There is always the exception, but most were interested and anxious to have more information." (Connell)
- "Experts say that teenagers are taking their cues from the adult world where being sexually active is the norm, but they worry that teenagers aren't getting either adequate sex education to understand the consequences of their behavior, or birth control information to prevent these births." (Ogintz)
- "The number of sexually active teenagers increased two-thirds in the 70's across the nation. That means that 12 million adolescents between the ages of 13 and 19 have had sexual intercourse. Nearly half of the sexually active, unmarried teenagers between the ages of 15 and 19 use contraceptives only occasionally. One-fourth of them never use them at all, and if this doesn't change, according to the Guttmacher Institute, four out of every ten young women will get pregnant at least once while they are a teenager." (Ogintz)
- "... in the schools the teenagers just have to be somehow better educated to what's happening and the consequences of what they are doing." (Ogintz)
- "The Caucus supports mandatory sex education in the public schools. I don't think that information necessarily leads to experimentation, although generally we realize that that's a hard argument to win. I think programs that provide not just family planning information or education but real sex education, that emphasize the values of family life, of responsible parenting, ... should involve parents as sex educators of their own children." (Hinds)

- "Planned Parenthood has had extensive programs that bring attention to the involvement of males, and not just in, again, the contraception, but in sexual activity and the sense of responsibility and own personal values that one should have before engaging in sexual activities." (Hinds)
- "And I would say that the boys indicated ... that the teen pressure to be sexually active was probably one of the greatest reasons for the amount of teenage pregnancies." (Jones)
- "... we do need more sex education ... both at home and in the school." (Jones)
- "... they thought that parents just made too much of a taboo of sex and the information about sex, and that we needed to explain some of the myths and taboos that apparently circulate. They seem to feel, too, that it was a very important issue in the life of young people as well as adults, and there should certainly be a wider circulation and understanding of the information regarding sexual activities and so forth." (Jones)
- "When we worked to establish the pregnancy program, both preventative and in the parenting skill area, the males are very difficult to involve. It's an area that really needs, I think, some research and some automatic attention." (Hinds)
- "... there is no place to take your child and learn how to be a parent whether you are a mother or a father." (Ginther)
- "One area that should not ever be overlooked is family planning." (Michelin)
- "... many of these kids become parents without realizing the responsibility or the consequences at all. They think pregnancy is the hard part." (Ogintz)
- "... immature physical and mental development of the teen-aged mother and father means chaos and is a definite break in the family link because of the parents' inability to cope with the stress and strain of parenthood." (Huntington)
- "Nutrition competes with a variety of other factors in peoples' lives. An infant of a teenage mother is more likely to grow up in economic deprivation, and his/her mother must have the skill and ability to make sound, informed decisions regarding the best way in which to use her limited resources to most adequately meet her child's needs. Teenagers as a group are not equipped with these skills." (Hinds)

- "Preventing nutritional problems is much easier than correcting them. Thus, we recognize that it is crucial that good nutritional habits be taught early to the mothers of these developing children. Infant feeding and nutrition is, therefore, a vital aspect of our program. By training mothers, this process insures the infant of obtaining his or her nutritional requirements and increases the chances of these good eating habits being maintained throughout their childhood." (Lutzker)
- "... these teenagers are leaving the hospitals with the baby in arms and barely know how to prepare a formula, let alone the introduction of solids...." (Garrick)
- "When asked how frequently she fed the baby, she said about every 8 to 10 hours depending upon how long she had to be at work. She also was not feeding properly." (Michelin)
- "... teaching them how to make decision, what proper parenting skills are, how to care for an infant. I'm not saying that adolescents can't make decisions, I'm just saying that oftentimes they don't." (Hinds)
- "Proper nutrition is not only ignored by the usually non-compliant adolescent during pregnancy, but is just as pronounced after the baby arrives. Therefore, when the problem concerning the proper nutrition of the pregnant adolescent is discussed, the concerns surrounding the nutrition of the teen mother and her new baby cannot be ignored." (Pasley)
- "From experience, I can tell horror stories of undiluted formula being administered, concoctions of syrup and water fed to babies, and table food fed to one-month-old babies to 'keep them quiet.'" (Pasley)
- "Pregnant teenagers should be given adequate counseling and education regarding the importance of prenatal and postpartum nutrition, breastfeeding, infant and child nutrition." (Maskay)
- "We have often found that these young women misinterpret what their physician or WIC nutritionist has suggested. For instance, four of our women have prepared formula and stored the bottles at room temperature. On one occasion, prepared bottles were kept on the windowsill, just above the radiator, during winter. When this mother was questioned about this procedure, she said she was following the doctor's instructions. Frequently, the mothers feed their infants cereal from the bottle because they do not feel the child is ready to be spoon fed." (Lutzker)

-- "The nutrition education program should also include areas dealing with child development and nutrition for children. Instructions should include: breast feeding; bottle feeding; weaning; food purchasing, preparation, and storage; nutrition and daily food requirements for children; (and) feeding techniques that could include ways of coping with special situations such as feeding a sick or handicapped child, which we have run into with our program. Teenage mothers should be taught that feeding means more than providing nutrients. It gives them an opportunity for the close physical contact with their infants that is so important in child development." (Hill)

BEHAVIOR PATTERNS OF TEENS
IDENTIFIED IN TESTIMONY

-- "The conception of a human life during the teenage years can, and often does, result in somewhat of a nine-month crash course in reality for the expectant teen. In the short span of nine months, a teen is transformed from a carefree young girl to a young woman with a sudden, new found sense of having a dependent other to deal with. And realistically, the teen does not actually allow herself the entire nine months to deal with her pregnancy. In too many cases of teenage pregnancy do we see several modes of behavior which all draw toward somewhat of a nutritional nightmare. Allow me to discuss three common first trimester reactions of the teen.

"The first, most common reaction is that of denying the pregnancy the first few months. Many teens think little of their first missed period. They worry a bit, but assure themselves that it will come next month. When the second period is missed, she worries more, but decides to give herself another month saying she is just upset and that has thrown her period off. By the end of the third month and completion of the first trimester, the teen has taken no steps toward prenatal care. And, at this time, she may begin to step-up something she has subconsciously been doing all along: dieting. Once the teen accepts that she is pregnant, she begins to worry about how soon she will begin to show. She skips breakfast; the most important meal of the day. At school, she skips lunch. At supper time she may eat, but only because her parents are looking on; and at that she will probably eat only small portions. Because today's youth are so poorly educated in nutrition, they relate weight gain to quantity rather than quality of what they eat.

"The second type of behavior I have come into contact with is that of the teen who leans toward an abortion. Abortion, along with topics such as sex, birth control, and pregnancy, are all topics that today's teens feel they have definite feelings about. They are either for or against a particular topic. Only when these topics come face-to-face with the teen, does the teen realize how very unsure their positions are on these topics. Thinking that she will simply have an abortion, the teen continues her regular habits the first few months of the pregnancy. She continues to smoke, drink, and eat as she pleases. By the time a teen actually begins to look into obtaining the abortion, she may find that either her pregnancy is too far along, she does not have enough money, or as in many cases of teen pregnancy today, she may find that she simply cannot go through with the procedure. This period puts the teen well into her second trimester; again with no prenatal care to date.

"The third behavior type is that of the teen who finds a so-called new sense of maturity within her pregnancy. She feels now she is 'a woman,' and knows what is best for herself and her baby. She may in all actuality know only old wives tales such as the one, 'eat what you like, dear, you're eating for two.' So she eats, and she eats and she eats." (Bennett)

- "Whereas nutrition is known to be essential for positive pregnancy outcome, teenagers are notorious for having poor dietary habits. They are often ignorant or misinformed about their nutritional needs, especially during pregnancy. Frequently, even when they are aware of nutritional needs, they are unable to translate knowledge into sound eating behaviors. They have relatively little influence on the decision-making process involved in meal planning in their homes. Generally, the teenager delays recognition and acceptance of the fact of pregnancy, and therefore, needed alterations in eating and other health related behaviors are also delayed. In some instances, she will even restrict her food intake in order to prevent continued weight gain, and at the other end of the spectrum, increased hunger being experienced due to the pregnancy may be relieved by eating excessive amounts of low nutrient density foods." (Maskay)
- "The problem is not one that can be measured by statistics alone; that elusive element known as 'behavioral modification' is involved. The problem looms regarding: (1) making a pregnant adolescent, who is often lacking good familial support, 'feel good' about her pregnancy, or (2) encouraging a pregnant girl that there are practical steps she must take to assure the health of herself and her baby when this girl fantasizes that she is 'in' because she is pregnant and that her baby will be 'fun.'" (Pasley)
- "The majority of pregnant adolescents I see indulge in fast foods, high calorie/low nutrition snacks, and routinely skip meals. Consequently, their diets lack important calories, protein, and iron. Ever conscious of their figures, these young girls often 'fast' or try bizarre fad diets after going on 'binges.' In addition, the adolescent client appears reluctant to gain weight in comparison to her adult counterpart. These behavior patterns pose serious implications for the mother and the child." (Murray)
- "The media has also contributed to the problem of portraying the slender female and robust male images. Most teen women within normal height and weight proportions consider themselves overweight and choose 'light junk' meals or not eating as a diet program. Males usually think they need to gain weight, regardless if they fall within the normal height and weight range." (Isberner)

- "It is not easy to arouse an adolescent's interest in diet and nutrition because the word 'nutrition' often connotes a boring subject. Since eating is a habit, pregnant teens have not given much thought to it, and they need to be motivated to change. In addition, these girls often have a poor self-image when they begin the program; they do not seem to care about their own bodies." (Barushok)
- "Since the average age of the pregnant teenager is fifteen to sixteen years, she will probably be subject to the emotional factors, developmental stresses, and moods that can impair nutrient metabolism." (Hill)
- "They have a low nutritional reserve and irregular eating habits, have been accustomed to skipping breakfast, and consuming soft drinks and snacks throughout the day." (Hill)
- "The point is that many adolescent girls are not adequately nourished before they become pregnant. The adolescent is still growing herself. She still wants the pencil-thin figure. How she looks still comes first. She is not knowledgeable enough about her own body, much less concerned for the unborn child she is carrying." (Hicks)
- "Now, consider that in some Chicago neighborhoods almost half of the babies being born have teenage mothers. This young woman ..., who is 16, told me that she was the eighth girl on her block to have a baby in the last several months. In her neighborhood, ... three out of every ten babies born are born to teenagers. ... those that work with those girls told me ... that many of these kids become parents without realizing the responsibility or the consequences at all. They think pregnancy is the hard part...." (Ogintz)
- "Social workers across the city told me that they felt like these kids weren't even aware, sometimes, of exactly what was going on biologically to themselves. They were almost shell shocked by the whole thing." (Ogintz)

PERTINENT STATISTICS

A. STATISTICS REGARDING THE EXTENT AND PROBLEMS OF TEENAGE PREGNANCY

Illinois

- "Across the state there is expected to be 30,000 new teenage mothers this year. That accounts for one out of every six births." (Ogintz)
- "The 1979 Vital Statistics indicate that the infant mortality rate in Illinois statewide is 14% higher than the national average." (Maass)
- "Based upon the most recent data available, 184,184 infants were born to Illinois citizens in 1979. Sixteen percent (29,800) of these infants were born to girls under 20 years of age. In contrast, however, of the neonatal deaths (infants dying before reaching 28 days of age) in 1978, more than 20% were infants of girls under 20 years of age. Furthermore, of the postnatal deaths (infants dying after 28 days of age but in their first year of life), 30% were infants of girls under 20 years of age. So, while teenage pregnancy was responsible for 16% of the births, it resulted in more than 20% of neonatal and 30% of postnatal deaths." (Maass)
- "In Illinois, approximately 18% of all pregnancies were borne to teenagers, 24% of all abortions are to teenagers, and 16% of the total births in the state are to teenagers, and the infant mortality rate was 15.1 per 1,000 live births in 1979." (Huntington)
- "Babies born to teenage mothers are much more likely to die in the first year of life than those born to mothers over the age of 20. Maternal mortality and morbidity, as well as the risk of having a low birth weight infant, are considerably greater among teenage mothers. Research has also shown that teenage mothers were 15% more likely to suffer from toxemia, 92% more likely to have anemia, and 23% more likely to suffer from complications attendant upon a premature birth than mothers who give birth at ages 20-24." (Hinds)
- "In 1979, 10% (2,863) of the live births to teenage girls were of low birth weight, compared to only 6% (8,801) for women age 20 years and older. Of the 2,863 low birth weight live infants born to teenagers, more than 10% died neonatally." (Maass)
- "Presently, the caseload of pregnant adolescents (aged 18 years or less) is 2,309, or 20% of the caseload of WIC pregnant women." (Maass)

Chicago Proper

- "... WIC statistics for 488 pregnant teenagers indicate that approximately 7% of the teenagers less than 15 years old have had previous pregnancies. Our WIC 15, 16, and 17 year olds, however, as expected, (have) a higher incidence of previous pregnancies by 15%, 22%, and 58% respectively." (Garrick)
- "The 1979 Vital Statistics indicate that the infant mortality rate ... in Chicago is 35% higher than the national average." (Maass)
- "Most of these new mothers, ... as young as eleven, will keep their babies. Most won't marry, and more than 60% will drop out of school. In Chicago, pregnancy is the leading cause for girls dropping out of school. More than a thousand a year, and that's only the number of kids that school officials are aware of." (Ogintz)
- "In 1979, total live births by teenage mothers that occurred in the City of Chicago were 12,354, or actually 22.6% of total live births in the city. We're always concerned about the very young teenager. Those under 15 numbered 378. ... there were actually about 615 teenagers (under 15) in 1979 (in Illinois) who gave birth to babies; there were 378 in Chicago. So we do have a substantial problem. If we added to those figures those that were 15, we add nearly another 900 to 1,000 more. If we add those that were 16 years of age, we add about 1,700 more. So, the figures are really quite significant in terms of teenage mothers in Chicago." (Taif)
- "The Chicago Board of Education has four Alternative Schools for Pregnant Girls which served 1,473 pregnant students in 1979; 26.8% of the 5,486 girls 17 years of age and under who gave birth in Chicago." (Hinds)
- "In 1979 in Chicago proper, 12,248 girls between the ages of 15-19 gave birth to a child, (and) 9,545 of these were pre-marital; 373 girls were between the ages of 10-14 giving live births, and 368 of these were pre-marital. The infant mortality rate was 20.5 deaths per 1,000 live births; the neonatal mortality rate (babies under 28 days old) was 13.1 per 1,000 live births." (Huntington)

Greater Chicago

- "In metropolitan Chicago in a six county area, there were 18,666 births to teenagers, which is 15% of the total births; 18,208 girls between the ages of 15-19 gave birth; and 12,248 of these were pre-marital." (Huntington)

- "At Crossroads during 1980, we confirmed over a thousand pregnancies to teenagers." (Michelin)
- "In the service area of Cook County Department of Public Health, which incorporates all of Cook County other than Chicago, approximately 5,500 teens gave birth in 1979. Therefore, 53% of the total births in Suburban Cook County were to women under 20 years of age. 31% of these births were to girls under 15 years of age. The illegitimacy rate was 41.4% in North Cook County, 44.8% in Central Cook County, and 55.9% in South Cook County." (Pasley)
- "Based on 1978 statistics, there are 13 suburban villages with populations of at least 25,000 which had infant mortality rates higher than the nation's rate of 13.6 per 1,000. The majority of these suburbs had infant mortality rates higher than Chicago's 15.6 per 1,000 rate for whites. The suburban areas of Harvey, Maywood, and Chicago Heights had infant mortality rates higher than the 26.6 per 1,000 rate of Chicago's non-whites. Particularly in the areas of Harvey (infant mortality rate 35 per 1,000), Maywood (30 per 1,000), and Chicago Heights (29 per 1,000), there is a high incidence of adolescent pregnancy." (Pasley)
- "In 1978 in suburban Cook County, 72.7% of adolescents who became pregnant had their first child; 27.3% were 'repeaters;' 10% of these teens had premature births. This percentage compares to the 5.6% of mothers 20 years of age or older who gave birth to premature babies." (Pasley)

Southern Illinois

- "The Bi-County Department of Public Health reports that during fiscal year 1981, 1,290 births were recorded in the two county area of Franklin and Williamson (Counties). Of those 1,290 births, 269 were to women 19 and under, which means 20.9% were born to teenagers. During FY 81, the Franklin/Williamson County WIC program saw a total of 136 pregnant adolescents." (Rowland)
- "Although Illinois has an average birth rate of 15.8 per 1,000 population in 1977, Alexander and Pulaski Counties experienced birth rates of 17.0 and 19.2 respectively. Infant mortality in Illinois was 15.9 in 1977. This compares to 18.6 for Alexander County and 27.3 for Pulaski County. Fetal and neonatal death rates also exceed state averages." (Kapro)

- "The percentage of live births which are premature (under 2501 grams) in Alexander and Pulaski Counties in 1969 were 9.2% and 17.0% respectively. Although this situation has improved over the past ten years, both counties still experience more premature births than the state as a whole." (Kapro)
- "Our current client caseload includes 180 prenatal women. Of that total, 64, or 35.5%, are adolescents." (Hill)

B. STATISTICS REGARDING NUTRITION EDUCATION

Statistics taken from "The Illinois Census of Secondary School Course Offerings 1977," Illinois State Board of Education, page 7, indicate that for the course entitled, "Foods and Nutrition":

- 120 high schools, or 17.04% of the state total, offered the course.
- The total enrollment of these schools was 111,207, or 16.60% of the total state enrollment.
- The total course enrollment was 5,929, or 0.89% of the total state enrollment and 5.33% of the enrollment of schools offering the course.

The 1979 Claims Data for Reimbursement, Formula Funded Programs, DAVTE, State Board of Education, gives the following information:

- Occupational Homemaking is a one-year general course. Family Health and Foods are two components of this course. Out of 676,106 high school students in Illinois, 39,983 students, or not quite 6%, took the course.

In Illinois between October, 1978, and January, 1981, the State Board of Education data shows that the United States Department of Agriculture's Nutrition Education & Training (NET) Act funds sponsored 230 projects in schools, reaching 252,472 preschool through 12th grade students.

C. ADDITIONAL STATISTICS SUBMITTED BY THE
ILLINOIS CAUCUS ON TEENAGE PREGNANCY

Extent of the Problem in Illinois

Statewide, approximately 18% of all pregnancies are to teenagers; 24% of all abortions are to teenagers, and 16% of the total births in the state are to teenagers.

In 1979, over 45,000 teenagers became pregnant; 65% of these resulted in live births.

In 1979, approximately 35% of all teenage pregnancies were terminated by abortion. There were 15,727 abortions to teenagers 15 to 19 years old and 414 to those under 15.

In 1979, there were 29,800 births to teenagers; 57.3% of these were premarital.

There were 29,186 girls between the ages of 15 to 19 who gave birth to a child in 1979; 16,467 (56.4%) of these were premarital.

There were 614 girls between the ages of 10 to 14 who gave birth to a child in 1979; 596 (97%) of these were premarital.

In 1980, 44,529 teenagers received family planning services from clinics funded by IFPC; teenagers represented 32% of the total caseload.

The 1979 Illinois infant mortality rate was 15.1 deaths per 1,000 live births.

Chicago Area

Six County Area:

In the six county area of metropolitan Chicago in 1979, there were 18,666 births to teenagers; 15% of the total births in the metropolitan Chicago area.

There were 18,208 girls between the ages of 15 to 19 who gave birth to a child in the six county area in 1979; 12,248 (67.3%) of these were premarital.

There were 458 girls between the ages of 10 to 14 who gave birth to a child in the six county area in 1979; 448 (97.8%) of these were premarital.

City of Chicago:

In Chicago in 1979 there were 12,621 births to teenagers; 22.5% of the total births.

There were 12,248 girls between the ages of 15 to 19 who gave birth to a child in Chicago in 1979; 9,545 (77.9%) of these were premarital.

There were 373 girls between the ages of 10 to 14 who gave birth to a child in Chicago in 1979; 368 (98.7%) of these were premarital.

In 1978, the Chicago infant mortality rate for teenagers 18 and under was 24.7 deaths per 1,000 live births compared to 23.7 for those 19 and older. The combined infant mortality rate was 23.9 deaths per 1,000 live births.

The 1979 Chicago infant mortality rate was 20.5 deaths per 1,000 live births; the neonatal mortality rate (for babies under 28 days old) was 13.1 per 1,000 live births.

The four Chicago Board of Education Alternative Schools for Pregnant Girls served 1,473 pregnant students in 1979; 26.8% of the 5,486 girls 17 years of age and under who gave birth in Chicago.

Problems of Early Pregnancy

The tax impact of teenage pregnancy and births are heavy, extending over years into the future. An estimated \$8.3 billion in government medical and welfare costs will accrue over a 20 year period as consequences of "first teenage births" in 1979.

Maternal death risk is 60% higher for younger teenagers than for women in their 20s.

Seven in 10 younger teenage mothers, under age 15, received no prenatal care in the first trimester. 6% of those under 15, and 3% of those 15 to 17 years old receive no prenatal care during pregnancy.

Babies of teenagers are 2 to 3 times more likely to die in their first year.

Babies born to teenagers are twice as likely to be premature and of low birth weight--major causes of infant mortality, birth injury, childhood illnesses, retardation and other neurological defects. One out of 4 low birth weight babies is born to a teenage mother, about 60,000 in 1974.

For all teenagers who become pregnant, 25% become pregnant again within a year; where prevention programs are not available, 44% become pregnant again within a year.

The suicide rate for teenage mothers is 7 times higher than the rate for teenagers without children.

Pregnancy is the most common cause of school dropout among young women. Teenage mothers are only half as likely to have completed high school; they are 4 to 5 times less likely to have completed college by age 29. Eight out of ten teenagers who become pregnant before the age of 17 never complete high school. Among teenage mothers 15 or younger, nine out of ten never complete high school; four out of ten never finish eighth grade.

In 1975, half of the money paid in Federal Aid to Families with Dependent Children went to families in which the mother gave birth while in her teens. Three out of 5 women in AFDC households have given birth as a teenager compared to one-third of the women in non-AFDC households. One out of 4 teenage mothers are AFDC recipients.

Two-thirds of the families with young children headed by mothers aged 14 to 25 lived below the poverty level in 1978; families with young children headed by mothers aged 14 to 25 are 7 times as likely to live below the poverty level.

Sixty percent of pregnant teenage brides are divorced or separated within 6 years of marriage. Young mothers ages 14 to 17 are 3 times more likely to separate or divorce within 15 years than those who postpone childbearing until their 20s: those who become parents at ages 18 to 19 are twice as likely.

Only 10 states and the District of Columbia require or encourage that sex education be taught in the public schools. Only 43% of the students aged 13 to 18 report having had sex education instruction in school.

Many teenagers, especially the never pregnant, find that family planning clinics will not accept them for service.

Eight in 10 day care centers will not accept children under the age of 2.

D. CASE INFORMATION

On the following two pages is case information submitted by a school nurse. The case information includes the outcome of pregnancy and what has happened to the mother educationally.

CASE INFORMATION 1979-80 SCHOOL YEAR

1. Gravida II.- Para II both, premature. First died at 2 or 3 months of age of pneumonia (born in the area of 2 to 3 pounds). - drop-out
2. Gravida I - Para I C. section - female, 8lbs. 5 oz.; normal - drop-out
3. Gravida II - Para II - normal deliveries. - Graduated
4. Gravida I - Para I Male, premature - transferred to Carbondale - Graduated
5. Gravida II - Para 0 Stillborn at 5 months; expected 1/82 - Attending-12th
6. Gravida I - Para I Normal, small birth weight - drop-out
7. Gravida I - Para I Normal birth and weight - Graduated
8. Gravida II - Para II Both C. section births (8th and 9th grade) - drop-out
9. Gravida II - Para II Normal births and weights - Attending 11th
10. Gravida II - Para II Normal births and weights - drop-out
11. Gravida I - Para I Normal birth and weight (homebound with severe vomiting in early pregnancy.) - Attending 11th
12. Gravida I - Para I Normal infant by C. section - Graduated
13. Gravida II - Para I Male infant, Weight 9lbs. 4½ oz. Severe anemia, mother and infant (infant transferred to Carbondale) - Graduated
(Expecting when graduated)
14. Gravida I - Para I Normal, 5lbs. 6 oz. (ninth grades) - drop-out
15. Gravida II - Para 0 Spontaneous abortion at 3 months, expected 1/82 - Attending 11th
16. Gravida I - Para I Premature, transferred to Carbondale, multiple deformities and health problems - Graduated
17. Gravida I - Para I Normal - drop-out
18. Gravida I - Para I Normal - Graduated
19. Gravida I - Para I C. Section, 10 lbs. 12 oz.; no rectum; transferred to St. Louis, Missouri - drop-out
20. Gravida II - Para I Normal, expected 1/82 - Attending 12th
21. Gravida I - Para I Normal - drop-out
22. Gravida III - Para II Normal births - drop-out
23. Gravida III - Para III - Twins one normal, one underweight and confined to hospital and extended care facility for first 2 years of life. Under service of Children and Family Services. Second pregnancy normal. Expecting 11/81, single fetus. - drop-out
24. Gravida II - Para I Normal delivery and weight expecting this fall - drop-out
25. Gravida II - Para II Small birth weights (5 lbs.) - Attending 12th
26. Gravida I - Para I Small birth weight, normal - drop-out
27. Gravida II - Para 0 Stillborn at 6 months; due 1/82 - Attending 11th

CASE INFORMATION
SCHOOL YEAR 1980-81 and 1981-82

1.	Gravida I - Para I	Normal male, mother positive sickle cell trait no transportation to W.I.C.	- Homebound 12th
2.	Gravida I - Para 0	Overdue, no complications so far	- Homebound 12th
3.	Gravida I - Para I	Low birth weight, infant expired at age 2- or 2 ½ months. Deformities of respiratory system and heart.	- Attending 12th
4.	Gravida II - Para II	Low birth weight, infants normal	- Attending 12th
5.	Gravida I - Para I	Normal male infant	- Graduated
6.	Gravida I - Para 0	Due 11/8/81 (W.I.C.)	re-enrolled & dropped out 10th
7.	Gravida I - Para 0	Due 11/81, Normal pregnancy, (W.I.C.)	- Attending 12th
8.	Gravida I - Para 0	Due 1/82, Normal pregnancy (W.I.C.)	- Attending 12th
9.	Gravida II - Para 0	Due 1/82, Normal pregnancy (W.I.C.)	- Attending 11th
10.	Gravida II - Para I	Due 1/82, Stillborn in 1979; normal pregnancy (WIC)	- Attending 11th
11.	Gravida II - Para 0	Due 1/82, Stillborn in 1979, normal pregnancy (WIC)	- Attending 12th
12.	Gravida II - Para I	Due 3/82 (W.I.C.)	- Attending 11th
13.	Gravida I - Para 0	Due 1/82, normal so far, attends clinic at Murphysboro, IL. Referred to W.I.C.	- Attending 11th
14.	Gravida I - Para 0	Due 1/82, normal pregnancy (W.I.C.)	- Attending 11th
15.	Gravida I - Para 0	Due 3/82 (W.I.C.)	- Attending 11th
16.	Gravida I - Para 0	Due 12/8/81 (W.I.C.)	- Attending 11th
17.	Gravida I - Para 0	Due 2/19/82	- Attending 11th
18.	Gravida II - Para 0	Spontaneous Abortion 1979; due 12/81; Rural Health at Dongola.	- Attending 11th

NUTRITION AND TEENAGE PREGNANCY

HEARING ATTENDANCE

September 15, 1981 - Chicago, Illinois

NAME	POSITION	ADDRESS	PHONE
1. Beth O'Laughlin	Nutrition Education Coordinator	Chicago Board of Education 160 W Wendell	641-8334
2. Edward Doornbos	Program Planner	Chicago IL. 60610 DCFS	785-2587
3. Carol Rose	Research and	Dept Human services	744-4083
4. Anne Silberman	Chief Planner	"	744-3132
5. Jane Broughton	Nutrition Coordinator	Chicago Dept of Health	744-3867
6. Joyce R. Garsnick	Public Health Nutritionist	"	744-3867 ^{with}
7. Hilda W. Wittington	Public Health Nutritionist	Deleg Center Chicago Dept. Health	744-3867
8. Hilde Nogly	Nutrition Education & Training Program	Chicago Board of Education 160 W. Wendell	641-8335
9. Steven T. Brown	NUTRITION EDUCATION CONSULTANT	MILK FOUNDATION 6 NORTH MICH 407	641-0895
S. Choler	WBBM		
10. Rob Lever	City News Breen		
11. Dolores M. Cahill	Chicago Sun-Times		793-2886 59

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NAME	POSITION	ADDRESS	PHONE
12. Ollie Keel	Superior	131 E 111th St	785-1174
13. Bruce Thomas	WIC - Roseland (Leg. Health Officer) IDPH	160 N. La Salle	793-3887
14. Katherine Claybrook	IDPH - WIC Field Rep.	160 N. La Salle	793-4393
15. Charles E. Guirio	LAC	160 N. La Salle	793-6190
16. Calum Muhammad	Nutritionist	1311 E. 111th St	785-1174
17. Rep Susan Cetaria			
18. Gileen Mulcahy Jensen	Health Planner IDPH - SHPD 4	160 N. La Salle Chgo	793-2690
19. Jenece Zyer			
20. Frances Denton, RN	Assistant Ed.	Chgo Dept of "Health"	744-6566 Wilson
21. Merry Jo Davis	Milk Foundation		
22. Carlene Bailey	Food & Drug Admin	433 West Van Buren Rm 1222	353-7126
23. Mathilda A. Jakubski	Gov. Special Asst on Ethnic Affairs	160 N. La Salle Room 2010	793-5454

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NAME	POSITION	ADDRESS	PHONE
24. Donald m Sheld m	} witnesses	1753 W. Harrison	942-6611
25. Peggy Hickala RD		1753 Harrison	942-5214
26. Laurie Kuljis MS.		1753 Harrison	942-6182
27. Harriet Sangster		303 E Superior	649-3058
28. Rep. Farrell (morning)			

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NAME	POSITION	ADDRESS	PHONE
1. April Vyboring	R. N. Diet-Nutrit	~~811~~ Southern Health Dept. Ulin, Ill.	634-2297
2. Cathy Kapiros	Nutritionist	529 Cross St Cairo, Ill.	134-4200
3. Nancy Rowland	Nutritionist	Christopher KHI P.O. Box 155, Christopher	724-2593
4. Fern Weiss, RN	Nutritionist	1224 N. Jefferson, St Louis	876-2383
5. Sharon Wells			
6. Phelma Nettles	student	701 E. Park, tr. #1	549-7075
7. MICHAEL BINGHAM	graduate Student Nutrition	112 1/2 N. Poplar	—
8. Kim K. Grosclaude	reporter - WSIU Radio	—	493-4343
9. Therese Synwischer	Student N & F	1520 Taylor Dr	549-2040
10. Hasnah Abdul-Rahman	"	144 Hall	549-7686
11. Kathy Poell	student	108 N. Springer	549-7147
12. Kate Gager	Nutr	Rt 1 Cobden	895-4491
13. ~~Anna Bennett~~	Social Worker	Rt 4, Metropolis	524-1370
14. ~~Chit Blair~~	Council Member	Springfield	217-782-1355

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NAME	POSITION	ADDRESS	PHONE
15. Paula J. Marks	Graduate asst.	Ambassador Apts #16	457-7728
16. Verditta Modicini	Registered nurse	PO Box 217 Tamm's del	747-2595
17. Janet O. Sundberg	Grad. Asst.	111 S. Glenview C'dale IL 62901	549-4405
18. Karen LaPorte	undergrad. student	337 Giant City Rd.	529-3424
19. Diana Bensit	undergrad. student	302 C. Hester C'dale, IL	457-5210
20. C. B. S. S.	'1		
21. Roy Sumner	Grad asst	1000 Emerald, C'dale	529-2618
22. Joyce Runeman	undergrad	608 E. Park #D	457-7824
23. Chris Shem	undergrad	803 W. Walnut	529-2638
24. Robert M. Ruckbers	WIC Field Rep	2209 W Main	
25. ~~Fred~~ Loslie Butz	Grad Student - NDDA Lab	(Regional State ofc Bldg)	997-4371
26. Beth Brauer	undergrad F&N - Dietetics	Human Development 720 N. Vine Apt 8	536-5541
27. Diana Stanley	Dietetics Senior S-I-U	DuQuoin, Ill 1195 E. Walnut	348-8387
			509-3132

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NAME	POSITION	ADDRESS	PHONE
28. Harriett Becker	RD	707 S Oakland Carbondale, Ill	457-6607
29. Marguerite Robinson		10507 Violet Ln Cdale, Ill	457-6548
30. Sylvia Bennett		RR1 Box 379 Spring Arbor Rd C'dale, IL	544-4738
31. Elizabeth Math		208 Emerald Lane Carbondale	62901
32. Judy Wagner		R#2 Box 137 Colider	893-2016
33. [Signature]		Box 234 C'dale	544-5367
34. Pam Mallory		205 Baldwin Hall / Thompson Pt	453-5531
35. Debra Haskinson		RR1, Box 165, Carbondale	457-8243
36. Connie Francis	Student	113 S Hewitt	549-6040
37. Pamela L. Coyner	WSIU Radio	212 S. University	549-6468
38. Helen Graef		613 S. Logan Apt B	549-4997
39. Karen Younger		800 Grand 30C	529-4513

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NAME	POSITION	ADDRESS	PHONE
40 Alma Hicks	Home Economics Teacher	Murphyboro, Ill	684-6607
41 Diane Stauffer	SIU-C Grad student	500 N. Westridge Apt. D21 Carbondale	681-2337 457-8864
42 Patz Buerkhogen	Student-Science	RR5, P.H. Tracts #3	549-0616
43 Betsy Luchman	SIU-C Grad Student	3095 James	5294784

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NAME	POSITION	ADDRESS	PHONE
1. Edward Dombos	DCFS	1 N. Old Capital Plaza Spfld	785-2587
2. Beth Haughlin	NET Coordinator-Chicago	160 W. Wendell Chicago, 60610	641-8334
3. Andrea M. Huntington	witness Northside Service Center	1454 N. Sedgwick Chicago, Ill 60610	312/ 266-7498 7578
4. Barbara Williams	Supervisor	17 N. Wabash, Ill 60602	332-2334
5. Sandra T. Brown	NUTRITION CONSULTANT	MILK FOUNDATION 6 NORTH MICH	641-0895
6. Hildegard Hogly	NET Program.	160 W. Wendell.	641-8335
7. Merry Jo Davis	Nutrition Conc	~~150 N.~~ 6 North Michigan Ave The Milk Foundation	641-0895
8. Charles E. Grinnex	LAC	160 N. LaSalle - 1118	793-6150
Valores McCall	Chicago Sun-Times		
Anne Galt	state representative	2801 South Michigan Ave	842-3011

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NAME	POSITION	ADDRESS	PHONE
10. Ken Davis	WBEZ NEWS		332-7337